U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 20Jun2002

Case No: 2001-BLA-1133

In the Matter of

HELEN M. MUCKER, Survivor of
GEORGE MUCKER
Claimant

v.

BETH ENERGY MINES, INC.
Employer

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS
Party-in-Interest

APPEARANCES:

John Gibson, Esq.
For the Claimant

John J. Bagnato, Esq.
For the Employer

BEFORE: MICHAEL P. LESNIAK
Administrative Law Judge

DECISION AND ORDER - REMANDING CLAIM

This proceeding arises from a claim for benefits under the "Black Lung Benefits Act", Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 et seq. ("Act"), and applicable federal regulations, mainly 20 C.F.R. parts 410, 718, and 727 ("Regulations"). In accordance with the Act and pertinent regulations, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs for a formal hearing.

Benefits under the Act are awarded to persons who are totally disabled within the meaning of the Act due to pneumoconiosis or to survivors of persons whose death was caused by pneumoconiosis. Pneumoconiosis is a dust disease of the lungs arising from coal mine employment and is commonly known as black lung.

A hearing was conducted on January 23, 2002 in Pittsburgh, Pennsylvania at which time all parties were afforded a full

opportunity to present evidence and argument as provided by the Act and the Regulations issued thereunder, found in Title 20, Code of Federal Regulations. The record was left open for the post-hearing submission of the deposition of Dr. Larry Hurwitz, which is herein admitted into the record as EX 6. The employer's closing argument was received on April 1, 2002. The claimant's closing argument was received on April 23, 2002.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witnesses who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations. References to DX and EX refer to the exhibits of the Director and the employer, respectively. The transcript of the hearing is cited as "Tr." and by page number.

ISSUE

The sole issue remaining for my resolution is whether the miner's death was due to pneumoconiosis. (Tr. 9; DX 32).

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Helen M. Mucker, is the widow of the miner, George Mucker. She has not remarried and has no dependents for purposes of augmentation of benefits. (Tr. 11-12, 16; DX 1, 5). The parties stipulated that the claimant is an eligible survivor of the miner, that the miner had thirty-five years of coal mine employment, and that he had simple pneumoconiosis which arose from his coal mine employment. (Tr. 8, 16; DX 3).

The miner filed two claims for benefits under the Act during his lifetime. The first claim was filed on June 22, 1973, and finally denied by the Benefits Review Board on October 30, 1984. Administrative Law Judge Reid C. Tait found that the interim presumption had been invoked by the pulmonary function studies, but rebutted by the preponderance of the evidence showing no pneumoconiosis and no pulmonary impairment. (DX 30). The miner's request to withdraw the second claim, which had been filed on November 15, 1985, was granted by Administrative Law Judge Gerald M. Tierney on March 23, 1990. (DX 31).

The miner died on July 22, 2000 at the age of seventy-five. The immediate causes of death are listed as coronary artery disease and chronic obstructive pulmonary disease. Coal workers' pneumoconiosis is listed as another significant condition. The certifier was Dr. Wallace E. Miller. (DX 6).

The claimant filed her claim for survivor's benefits on August 10, 2000. (DX 1; Tr. 8). The employer was notified of the claim and subsequently controverted based on the claimant's eligibility. (DX 17, 18, 22, 23). The District Director, Office of Workers' Compensation Programs ("OWCP") denied benefits on January 10, 2001 and May 22, 2001. (DX 12, 27). The claimant timely requested a formal hearing, and the claim was referred to the Office of Administrative Law Judges ("OALJ") on August 13, 2001. (DX 13, 28, 32, 33).

Medical Evidence

The following is a summary of the medical evidence of record:

A. Chest X-rays

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications[1]	Interpretation[2]
DX 30.18	10/8/73	Good	Webster	1/0, q, 6 zones.
DX 30.15	10/8/73	+	Sargent/BCR, B	1/1, q, 4 zones.
DX 30.35	6/14/76	-	Illegible (Hospital)	Heart normal. Lungs clear.
DX 30.16	1/31/79	1	Morgan/BCR, B	Completely negative.
DX 30.19	1/31/79	-	Horwin	Normal.

[1] The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2).

The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a physician who has demonstrated expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

[2] Under the provisions of § 718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of § 718.102 may form the basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B, or C under an internationally-adopted classification system. An x-ray classified as Category 0, including subcategories 0/-, 0/0 and 0/1, does not constitute evidence of pneumoconiosis. Under §718.202(a)(1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays. The interpretations of physicians dually-qualified as board-certified radiologists and B readers may be given more weight than the interpretations of B readers. Worhack v. Director, OWCP, 17 B.L.R. 1-105, 1-108 (1993); McMath v. Director, OWCP, 12 B.L.R. 1-6, 1-8 (1988); Sheckler v. Clinchfield Coal Co., 7 B.L.R. 1-128 (1984).

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation
DX 30.20	8/30/79	-	Gress	No active lesion of the chest. 0/0.
DX 30.17	8/30/79	2	Sargent/BCR, B	Completely negative.
DX 30.33	7/15/80	1	Palmer	Completely negative.
DX 30.42	10/30/80	1	Illegible/BCR	Completely negative.
DX 31.31	10/10/83	-	Illegible/BCR	Completely negative.
DX 31.43	10/10/83	-	Kaplan/B	0/0.
DX 31.31	6/5/84	-	Patterson	0/0.
DX 31.17	1/17/86	1	Greene/B	Completely negative.
DX 31.21, 31.15	1/17/86	1	Klemens	1/1, p/s, 6 zones.
DX 31.18	1/20/86	1	Palmer/BCR, B	No reading given.
DX 31.19	1/20/86	1	Wolfe/BCR, B	Completely negative.
DX 31.20	1/20/86	1	Patterson/B	Completely negative.
DX 31.31	1/20/86	1	Wertz/BCR	Completely negative.
DX 31.41	1/20/86	1	Mathur/BCR, B	2/2, p/s, 6 zones.
DX 31.35	3/11/88	Good	Klemens	1/2, p/s, 6 zones.
DX 31.38	3/11/88	1	Tristan/B	1/0, p/q, 6 zones.

DX 31.44	3/11/88	1	Wolfe/BCR, B	Completely negative.
DX 31.44	3/11/88	1	Palmer/BCR, B	Completely negative.
DX 31.43	3/23/88	1	Fino/B	Completely negative.
DX 31.41	3/23/88	1	Mathur/BCR, B	2/2, p/s, 6 zones.
EX 3	4/22/97	1	Fino/B	0 / 0 . Cardiomegaly.

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation
EX 3	4/24/97	1	Fino/B	0 / 0 . Cardiomegaly.
EX 3	1/1/99	1	Fino/B	0 / 0 . Cardiomegaly.
EX 3	1/2/99	3	Fino/B	0 / 0 . Cardiomegaly.
EX 3	1/3/99	3	Fino/B	0 / 0 . Cardiomegaly.
EX 3	1/5/99	3	Fino/B	0 / 0 . Cardiomegaly.
EX 3	1/7/99	1	Fino/B	0 / 0 . Cardiomegaly.
EX 3	7/5/00	1	Fino/B	0 / 0 . Cardiomegaly.

B. Autopsy Evidence

An autopsy was performed on July 22, 2000 by Dr. Maged Hanna, a pathology resident, and Dr. Vimal Mittal, a forensic pathologist. Their final diagnoses were: status post coronary bypass graft, patent bypass graft; triple coronary artery disease, severe, 90% to 100% occlusion, cardiomegaly (heart weight 1200 grams), biventricular hypertrophy; pleural effusion, bilateral (total 2500 cc), coal workers' pneumoconiosis, macular and micronodular, focal emphysema; and chronic passive congestion, liver. They concluded that the miner "died of underlying severe coronary artery disease. In addition, both lungs reveal significant coal workers' pneumoconiosis in the form of macules and micronodules which also

contributed to his final demise."

I note that these physicians indicated that they took multiple sections from both lungs showing the macules and micronodules distributed to the subpleural, peribronchial, and perivascular regions. (DX 7).

Dr. Joshua A. Perper reviewed the autopsy slides and hospital records on behalf of the OWCP, and issued a report on December 2, 2000. Dr. Perper's microscopic diagnoses were simple coal workers' pneumoconiosis, slight to moderate; centrilobular emphysema, variable, slight, focal; coronary arteriosclerosis, marked; hypertrophy; and myocardial scarring consistent with prior healed myocardial infarction. He noted that "centrilobular emphysema has been ascribed both to smoking and occupational exposure of miners to coal mine dust and coal workers pneumoconiosis." Dr. Perper concluded that:

> There is no evidence that coal workers' pneumoconiosis was a substantial contributory cause of Mr. Mucker's death or that it hastened his death. Mr. Mucker had at autopsy evidence of heart failure with a large amount of fluid in the chest cavities, an unusually huge heavy and enlarged heart (cor bovinum) and severe coronary artery disease, all pointing to the fact that the major and most likely the sole cause of death was the hypertensive and arteriosclerotic cardio-vascular disease. It is very unlikely that the mild to moderate coal workers' pneumoconiosis and the associated mild and focal centrilobular emphysema contributed in any way to the death or hastened Mr. Mucker's death. The available medical clinical documentation substantiated repeatedly ischemic events, both myocardial and extra-myocardial (e.g. the stenosis of carotid arteries) due to occupationally unrelated arteriosclerosis. It is true that the clinical records mention also a diagnosis of COPD, but this diagnosis was not supported in the available medical documentation, which did not include any records addressing any primary respiratory clinical symptomatology or any objective data (chest X-Ray reports, ventilatory studies or arterial blood gases) indicative of respiratory disease or respiratory impairment. Furthermore the patient's medications did not included (sic) respiratory medication such as bronchodilators or inhalers.

Dr. Perper's opinion remained the same after he reviewed additional evidence on the miner's occupational and smoking histories sent to him by the OWCP. It is noted, however, that the OWCP did not provide him with the other medical information Dr. Perper noted he needed to properly address the issue of COPD and any respiratory impairment. (DX 8).

Dr. Stephen J. Bush reviewed the autopsy slides and medical records on behalf of the employer, and issued a report on January 30, 2001. He concluded that:

> ... There is no causal relationship between the mild to moderate degree of simple coal worker's pneumoconiosis or coal mine dust exposure and death. The changes in the lungs due to coal mine dust exposure are too limited in degree and extent to have made any contribution to the events resulting in the death of Mr. Mucker at the age of 75 years.
>
> ... Mr. Mucker would have died at the same date, time, and manner if he had never been exposed to an occupational pulmonary disease hazard. The cardiac disease, unrelated to the limited degree of disease in the lungs, was inevitably fatal in spite of maximum surgical and medical efforts to control the heart failure and correct the obstructive coronary artery atherosclerosis.
>
> ... Mr. Mucker did not have cor pulmonale. The clinical records and autopsy findings indicate bi-ventricular hypertrophy consistent with a chronically failing left ventricle which secondarily affected the right ventricle causing both to be thickened. The change of the right ventricle in this circumstance is not the result of primary lung disease. If primary lung disease were to cause thickening of the right ventricle, the disease would necessarily be severe, diffuse, bilateral changes that cause obstruction of pulmonary vessels and an increase in pulmonary artery pressure. Such disease is not present in the lungs clinically, radiologically or pathologically.

Dr. Bush is board-certified in anatomic and clinical pathology, and medical microbiology. (DX 21). Pages 2 and 3 of this report are missing from the record.

Dr. Richard L. Naeye reviewed the autopsy slides and medical records on behalf of the employer, and issued a report on March 16, 2001. Dr. Naeye noted that "[t]here is no quantitation in the autopsy report of the overall number of anthracotic macules and micronodules in his lungs apart from the assertion that 'the pleural surfaces of the lungs display anthracotic pigment up to 70% of their surface'", and that "[p]ulmonary function studies conducted during the last years of his life produced results that cannot be interpreted, i.e. they were invalid because he was unable to perform the strenuous physical requirements of the tests." He concluded that:

> The disorder that dominated this man's life was severe

> arteriosclerosis in his coronary arteries. It led to disability and may have been the reason for his quitting mining coal at 56 years of age. The microscopic findings of anthracotic macules and micronodules with associated fibrosis in this man's lungs suggest the presence of moderately severe, simple coal worker's pneumoconiosis (CWP). However, the tissues from which this diagnosis was made proved to be unrepresentative of his lungs as a whole because his late life chest x-rays were interpreted as negative for CWP by very experienced radiologists. The most important finding in determining if this man had any disability due to lung disease is the fact that centrilobular and focal emphysema in combination were mild. Without more severe emphysema there is no possibility that his CWP could have caused any disability or hastened his death. No bronchi are available for microscopic review but the clinical history does not suggest he had clinically significant chronic bronchitis. Chronic bronchiolitis was absent.

Dr. Naeye is board-certified in anatomic and clinical pathology. (DX 24).

Dr. Joseph F. Tomashefski reviewed the autopsy slides and medical records on behalf of the employer, and issued a report on May 3, 2001. He concluded that:

> [The miner] had severe, end-stage, atherosclerotic and hypertensive cardiac disease, which had resulted in massive cardiomegaly, pleural effusions and ascites, chronic passive congestion of the lungs and liver, and biventricular myocardial hypertrophy. Within reasonable medical certainty, the underlying cause of Mr. Mucker's death is congestive cardiac failure, while the immediate cause of death is an acute myocardial ischemic event.
>
> Based on the findings of coal macules and micronodules it is also my opinion that Mr. Mucker had mild simple coalworkers' pneumoconiosis. His simple coalworkers' pneumoconiosis is of very mild degree, and in my opinion would not have caused Mr. Mucker any respiratory symptoms or exercise limitation. It is also my opinion that Mr. Mucker's mild simple coalworkers' pneumoconiosis neither caused nor contributed to his death.
>
> Mild centriacinar emphysema is an additional finding in Mr. Mucker's lung tissue. Emphysema is of very minimal extent and, in my opinion, would not have caused Mr. Mucker any significant respiratory impairment. Within reasonable medical certainty, Mr. Mucker's mild centriacinar emphysema was not caused by coal dust

exposure or simple coalworkers' pneumoconiosis; but rather, by his exposure to cigarette smoke over an approximately 30 year period. The minimal extent of Mr. Mucker's simple coalworkers' pneumoconiosis and emphysema are reflected in the absence of radiographic findings of either of these conditions in the majority of

his chest x-ray reports, and the very mild obstructive changes in his pulmonary function tests of 12/13/89. Within reasonable medical certainty, Mr. Mucker's mild centriacinar emphysema neither caused nor contributed to his death.

Dr. Tomashefski is board-certified in anatomic and clinical pathology. (DX 25).

In response to an inquiry from the claimant's counsel, Dr. Mittal wrote on May 17, 2001 that the miner had CWP with associated emphysema; that although the CWP was simple, the severity was of a moderate degree; and that "[t]he CWP was a substantial contributing cause in his death as well as the associated emphysema which together caused hypoxemia complicated by fatal cardiac arrhythmia." (DX 26).

Dr. Bush was deposed on January 9, 2002. He testified that a combination of coal workers' pneumoconiosis and emphysema can be severe enough to cause hypoxemia and result in death with a cardiac arrhythmia, but that did not happen in this case because the pneumoconiosis was "so limited in degree and extent, hypoxemia was not a result of this condition." (EX 5).

C. Pulmonary Function Studies

Date	Ex. No.	Age/Hgt.		FEV1	FVC	FEV1/ FVC	MVV	Coop/ Comp.
3/1/79	DX 30	54/68"		2.25	3.09	73%	71.3	Good/
			*	2.40	3.25	74%	85	Good
8/24/79	DX 30 .31	54/68"		1.5	1.8	83%	54.5	Good/ Good
7/15/80	DX 30 .33	55/68"		1.9	1.9	43%	31	Good/
			*	1.45	2.5	33%	8	Good
10/30/80	DX 30 .42	55/68"		2.34	2.92	80%	62.4	- -
4/14/83	DX 31 .12	58/67.75"		2.3	2.7	- -	53	Good/ Good
11/17/83	DX 31 .31	58/68"		1.88	2.37	79%	66	- -

Date	Ex. No.	Age/Hgt.	FEV1	FVC	FEV1/ FVC	MVV	Coop/ Comp.
6/5/84	DX 31	59/66.5"	2.55	2.73	- -	67	Good/

	.31		* 2.26	2.97		79	Good
1/17/86	DX 31 .13	61/68"	2.34	2.7	- -	70	Good/ Good
1/20/86	DX 31 .31	61/68"	2.2	2.9	76%	58	- -
3/11/88	DX 31 .35	63/69"	2.20	3.18	- -	78	Good/ Good
3/23/88	DX 31 .43	63/66"	2.15 * 2.31	3.10 3.16	69% 73%	61 74	Good/ Good

* Results obtained post-bronchodilator.

D. Arterial Blood Gas Tests

Date	Physician	pCO2	pO2	Ex. No.
3/1/79	Strother	38 38	85 80	DX 30.12
10/30/80	Bloom	36	76	DX 30.42
10/10/83	Lantos	32.4 ** 29.8	89 101.5	DX 31.31
1/20/86	Gress	35 ** 35	73 88	DX 31.31
2/18/86	Strother	39	81	DX 31.16
3/23/88	Fino	35	82	DX 31.43

** Results obtained with exercise.

E. Medical Opinions

On June 14, 1976, while at work in the mines, the miner developed chest pains, sweating and nausea. He was admitted to the Windber Hospital. An electrocardiogram was given which showed he had suffered an acute myocardial infarction. He was released after a two week hospitalization, put on medication and his activities restricted. In September 1976, his family doctor, James Barefoot, referred him to Dr. V.P.S. Dhawer at the Lee Hospital where a catheterization of the heart was performed and revealed that the lumen of the right coronary artery had a narrowing of "about 95% or so." The anterior descending coronary artery had localized narrowing of about 25% and the circumflex artery was narrowed some 35%. The diagnosis upon discharge was arteriosclerotic heart disease. Dr. Dhawer noted that there was significant right

coronary artery disease which required medical treatment. He also felt if the condition continued that surgery might be considered. (DX 30.13, 30.35, 10).

The miner was referred by his family doctor to Dr. Thomas J. Cardellino on March 30, 1978. Dr. Cardellino reported the miner had been getting a good deal of chest pain on exertion which he felt was due to coronary insufficiency. He noted the miner was taking Serax, Inderal, Apresazide and Apresoline, all of which are medications for the heart, nerves and hypertension. Dr. Cardellino prescribed sorbitrate to help prevent attacks of angina and advised him to avoid strenuous activity. On April 30, 1978, Dr. Cardellino reported that the miner still had chest pains if he "over does it." He was advised not to return to his previous heavy strenuous work and if that was not feasible, he should go for total disability. On June 22, 1978, Dr. Cardellino noted that the miner had returned to work at a less strenuous job, but still gets a little burning in the chest on excessive physical activity. He continued the medication and suggested that the miner remain with his family doctor for medical care. (DX 30.25).

On March 15, 1979, Dr. James E. Barefoot examined the miner and reported to the OWCP. His diagnoses were: 1. arteriosclerotic cardiovascular disease with coronary insufficiency and angina, 2. symptomatic lung disease from working in the underground coal mining industry. He noted in the history that the miner had never taken any medications for any lung condition. His medical assessment was that the impairment was non-severe as far as his lung disease, however, was relatively severe because of the cardiovascular problems. Dr. Barefoot also reported that the miner had increased angina attacks recently and required increased medication. (DX 30.14).

Dr. Gordon A. Gress examined the miner on August 24, 1979. He found atherosclerotic heart disease with a positive Master’s exercise tolerance test and catheterization evidence of heart disease as well as hypertensive vascular disease. Dr. Gress found no evidence of coal worker’s pneumoconiosis on x-ray. It was his medical opinion, based on all the evidence he had, that the miner did not have pneumoconiosis and was not disabled by that disease. He was disabled as a result of atherosclerotic coronary artery disease. (DX 30.30, 30.32). In deposition testimony, Dr. Gress stated that the miner might have some pulmonary problem, but it was not disabling. His overwhelming problem, and the one which rendered him totally disabled, was the heart disease. (DX 30.37).

On July 15, 1980, the miner was examined by Dr. Sheonath P. Srivastava. He found ischemic heart disease, hypertension, and chronic bronchitis. Dr. Srivastava stated that he was sure the working in the dusty atmosphere in the mines for 33 years contributed to the miner’s chronic bronchitis. He said he was totally disabled because of shortness of breath. (DX 30.33). In

a deposition, Dr. Srivastava testified that the miner had given no history of serious chest pain and the medication he was taking controlled the hypertension. He concluded that the miner's disability was a result of chronic bronchitis. On cross-examination, Dr. Srivastava stated that he did not consider the miner's heart disease to be significant. He also said that chronic industrial bronchitis was a progressive disease. Dr. Srivastava stated that there was no pneumoconiosis on x-ray and his diagnosis of chronic bronchitis was based on the miner's shortness of breath, the miner's description of a dry cough, and a reduction in the pulmonary function tests. He also said that chronic industrial bronchitis was progressive even after a person is removed from exposure to irritants. He could not determine whether the bronchitis was due to the miner's dust exposure or cigarette smoking history, however, he did say "one aggravated the other." (DX 30.34).

Dr. Meyer Bloom examined the miner on October 30, 1980 on behalf of the employer. It was noted that following a heart attack in June 1976 and a six month recovery period, the miner returned to a lighter job. However, on January 4, 1980, he quit due to severe pains. Examination of the chest was normal. An x-ray was negative for pneumoconiosis. A pulmonary function study was fairly normal. Arterial blood gas tests and an electrocardiogram was also obtained. Dr. Bloom diagnosed severe coronary artery disease to which he stated that reduction in pCO2 "could be attributed." He also found high blood uric acid. Dr. Bloom concluded that there was no evidence of an occupationally acquired lung disease, and that the miner was totally disabled due to his heart disease. (DX 30.35, 30.42). Dr. Bloom also testified by deposition concerning his findings. (DX 30.38).

Dr. Robert F. Klemens, who is board-certified in internal medicine, examined the miner on April 14, 1983. Dr. Klemens reported that the miner stopped working on January 4, 1980, as he could no longer do his work as "[t]he cold air and the dust in this work was causing him too much trouble with his breathing." The smoking history was 1 to 1 1/2 packs of cigarettes per day, quitting twelve years prior. Examination revealed clear lungs. An x-ray was positive for pneumoconiosis, 1/1. A pulmonary function study was also obtained. Dr. Klemens diagnosed coal workers' pneumoconiosis, 1/1; arteriosclerotic heart disease with history of remote myocardial infarct, compensated heart; and vascular hypertension, controlled. He found the miner to be totally disabled from a pulmonary standpoint, explaining that:

> In reaching my opinion, I have given consideration to his complaints, the types of work that he has done in the past, the nature of his last work as a coal miner, the types of light activity of daily living that now produce shortness of wind, features of his physical examination and the findings of his breathing assessment

and chest x-ray.

(DX 31.14).

Dr. Raymond J. Lantos, who is board-certified in internal medicine, examined the miner on October 10, 1983 and issued a report on December 1, 1983 on behalf of the employer. The miner had stopped smoking fourteen years ago. Examination revealed that the chest appeared slightly emphysematous. An x-ray was read as negative for pneumoconiosis. An arterial blood gas test was normal both at rest and after exercise. Pulmonary function study results from November 17th suggested both restrictive and obstructive defects but due to the miner's ability to perform, the test was completely unsatisfactory and thus invalid. An electrocardiogram revealed Q waves in 2, 3, and AVF, along with the T wave changes were residual of a previous heart attack. Dr. Lantos diagnosed arteriosclerotic heart disease with remote inferior wall myocardial infarction, and essential hypertension - on therapy. He concluded that the miner's symptoms were "most probably the result of his cardiac disease. With this conclusion there is no reason that he couldn't perform his previous duties from a pulmonary standpoint." (DX 31.31).

Dr. Robert G. Pickerill examined the miner on June 5, 1984. The smoking history was one pack of cigarettes per day for thirty years, quitting in 1971. A pulmonary function study revealed a mild restrictive defect. (DX 31.31).

The records of Windber Hospital show that the miner was hospitalized from July 29 to 30, 1985, and from August 18 to 22, 1985 due to severe stenosis of the left internal carotid artery with amaurosis fugax. It was noted that the miner began smoking again recently. The attending physician was Dr. B.T. Aguilera. (DX 31.30, DX 10). The miner's daughter, Patricia A. Fyock, wrote that the notation of smoking in these records was in error. She stated that her father "quit smoking in 1970 and never resumed. He had his first heart attack on 6/14/76 and was told by the doctor that if he had been smoking cigarettes he most likely would have died from this heart attack. All who knew him knows that he never started to smoke cigarettes again." (DX 11).

Dr. Klemens examined the miner again on January 17, 1986. The smoking history was 1 to 1 1/2 packs of cigarettes per day for twenty-five years, ending in 1971. Examination revealed clear lungs. An x-ray was positive for pneumoconiosis, 1/1. Dr. Klemens diagnosed coal workers' pneumoconiosis and arteriosclerotic heart disease. Arrangements were made for an arterial blood gas test with Dr. Strother. (DX 31.15).

Dr. Gordon A. Gress examined the miner on January 20, 1986 on behalf of the employer. The smoking history was 1 1/2 packs of cigarettes per day from age eighteen to age forty-six. Dr. Gress

noted that the miner took all of his medication prior to the examination except for the bronchodilator inhaler. Examination revealed a symmetrical and stocky chest with clear lungs. An x-ray was negative for pneumoconiosis. Pulmonary function studies showed uniformally mildly to moderately decreased values, compatible with a mixed obstructive and restrictive pulmonary disease. Arterial blood gas tests showed mild reduction in oxygen tension at rest with normal increase with exercise. A resting electrocardiogram revealed a QS type complex in lead III, an old inferior infarction was not excluded. The post-exercise cardiogram was highly suspicious for ischemic heart disease. Dr. Gress reviewed additional medical records, including his 1979 examination of the miner. Dr. Gress concluded that:

> Mr. George Mucker has atherosclerotic heart disease, with probable single vessel disease, and with associated positive treadmill test, with recurrent angina pectoris. He also has some evidence by pulmonary function studies of chronic obstructive pulmonary disease, related to a 40 pack-year history of cigarette consumption.
>
> I find no evidence of any pneumoconiosis or any occupationally-related pulmonary disease in Mr. Mucker and therefore, I find no disability on that basis.

(DX 31.31).

Dr. Gress was deposed on March 9, 1988. He reiterated his examination findings, in particular that the miner had emphysema but not pneumoconiosis. He stated that the miner was "probably not disabled on the basis of his respiratory function alone; although, there are times when he might have difficulty doing his job because of some dyspnea and some wheezing." He further testified that coal dust exposure can cause chronic bronchitis, but not emphysema, and that frequently emphysema and heart disease "travel together". Yet he also testified that the pulmonary function study results were consistent with both a condition due to cigarette smoking and a condition due to pneumoconiosis. The arterial blood gas test results were equally non-specific. As to any contribution from coal dust exposure, Dr. Gress testified that:

> I think that there most likely is a degree of contribution. He worked 36 and 3/4 years, it was all underground. I would consider it as a factor in the etiology of his current pulmonary condition, but not a significant factor. It’s not a significant factor because of his chest x-ray which doesn’t show any rounded or irregular opacities.

Dr. Gress is board-certified in internal medicine. (DX 31.34).

Dr. Klemens examined the miner again on March 11, 1988. The

smoking history was 1 to 1 1/2 packs of cigarettes per day beginning at age seventeen, and quitting seventeen years prior to the exam. In addition to his cardiac medication, the miner was on a Vanceril spray for his lungs. Examination revealed clear lungs. An x-ray was positive for pneumoconiosis, 1/2. A pulmonary function study revealed a mild restrictive and moderate obstructive impairment. Dr. Klemens diagnosed coal worker's pneumoconiosis, 1/2; and arteriosclerotic heart disease with compensated heart. He again found the miner to be totally disabled from a pulmonary disability. (DX 31.35).

Dr. George W. Strother reviewed the March 11, 1988 pulmonary function study and found it to be invalid. Dr. Strother is board-certified in internal and pulmonary medicine. (DX 31.44).

Dr. Gregory J. Fino, who is board-certified in internal and pulmonary medicine, examined the miner on March 23, 1988 on behalf of the employer. The smoking history was one pack of cigarettes per day from 1941 to 1971. The miner was on Proventil and Vanceril inhalers; however, neither was used on the day of the examination. The miner stated that the inhalers helped him with wheezing, and that he had used them for two years. Examination of the lungs was normal. An x-ray was read as 0/0. A pulmonary function study was also obtained, which Dr. Fino concluded showed poor effort pre-bronchodilator and better effort post-bronchodilator. He did not attribute the post-bronchodilator improvement to the use of the bronchodilator. The diffusing capacity was normal, as was an arterial blood gas test. An electrocardiogram was abnormal with changes consistent with an old inferior wall myocardial infarction with Q waves in Leads II, III, and AVF. Dr. Fino also reviewed additional medical records. Dr. Fino concluded that the miner did not have coal workers' pneumoconiosis nor a respiratory impairment. He found the miner totally disabled from a cardiac standpoint. (DX 31.43).

Dr. Lantos was deposed on April 11, 1988. He reiterated his findings. (DX 31.40).

Dr. Peter D. Kaplan reviewed medical records on behalf of the employer and issued a report on April 25, 1988. He concluded that:

> In view of the overwhelming number of reports and my personal review of a film in 1983, I don't believe that there is any radiographic evidence to support the diagnosis of coalworker's pneumoconiosis. The patient's lung function has been somewhat variable relating to his inconsistency in performing the tests in a reliable fashion. If he does have significant lung dysfunction, I believe it is related to his cigarette smoking. His symptoms, to some physicians describing shortness of breath at rest, are out of proportion in any case to his lung function and could be attributed to another cause

> such as his heart disease or perhaps be on an anxiety basis.

He found the miner disabled from heart disease. Dr. Kaplan is board-certified in internal and pulmonary medicine. (DX 31.43).

Dr. Robert G. Pickerill, who is board-certified in internal and pulmonary medicine, reviewed medical records on behalf of the employer and issued a report on December 18, 1989. He found the April 14, 1983, November 17, 1983, June 5, 1984, January 17, 1986, January 20, 1986 (MVV only), March 11, 1988, and March 23, 1988 (MVV only) pulmonary function studies were invalid. He noted that the miner was on Proventil and Vanceril inhalers for COPD. Dr. Pickerill concluded that there was no evidence of an occupational pulmonary disease and that the miner did not have any significant functional respiratory impairment. He found the miner to be totally disabled due to his heart disease. (DX 31.50; see also March 31, 1988 review, DX 31.39).

Dr. Fino was deposed on January 19, 1990. He reiterated his examination findings and, after reviewing additional medical records,
stated that regardless of whether the miner had pneumoconiosis, the miner did not have any pulmonary disability. (DX 31.52).

The records of Conemaugh Valley Memorial Hospital show that the miner was hospitalized from December 2 to 9, 1994 due to atrial flutter/fibrillation. Chronic obstructive pulmonary disease was noted to be stable. A myocardial infarction was ruled out. The miner was treated and released. (DX 9).

The miner was rehospitalized from January 25 to 31, 1995 due to coronary artery disease. On January 26th, he underwent a redo of the coronary artery bypass grafting.

The miner was then hospitalized from April 22 to 24, 1997 due to congestive heart failure. The discharge diagnoses included chronic obstructive pulmonary disease.

The miner was next hospitalized from January 1 to 9, 1999 due to fever, confusion, lung congestion, pneumonia, chest pain, right leg pain, angina, and anxiety. The discharge diagnoses were small myocardial infarction confirmed with EKG changes and enzymes; pneumonitis and congestive heart failure. (DX 10).

Dr. Larry E. Hurwitz reviewed medical records on behalf of the employer and issued a report on June 27, 2001. He concluded that:

> Mr. Mucker died of progressive atherosclerotic coronary disease terminating in fatal cardiac arrest manifested by asystole. The terminal event was the result of progressive severe biventricular dysfunction.
>
> In my opinion, the presence of coal worker's pneumoconiosis played no role in progressive coronary artery and myocardial disease. It is my opinion, with reasonable medical certainty, that Mr. Mucker would have died at the same time and place had he not been exposed to respirable coal dust.

Dr. Hurwitz is board-certified in internal and cardiovascular medicine. (EX 1).

Dr. Steven P. Griffin also reviewed the medical records on behalf of the employer, and issued a report on September 20, 2001. Dr. Griffin concluded that:

> Mr. Mucker died as the result of severe coronary artery disease, causing heart failure. Review of autopsy slides shows the presence of myocardial fibrosis and vivid red staining of some remaining myocardial cells is consistent with ongoing ischemia. Coronary vessels show

> severe narrowing. Lungs show the presence of hemosiderin-laden macrophages (heart failure cells), and his liver shows marked passive congestion (cardiac cirrhosis) as further evidence of a failing heart. His clinical records contain evidence of disability from coronary artery disease including coronary artery bypass surgery performed on two separate occasions, and more recently, hospitalization beginning April, 1997, for congestive heart failure.
>
> ... [T]he mild degree of simple coal workers pneumoconiosis found in Mr. Mucker's lungs is too mild to have caused him any measurable degree of pulmonary dysfunction and therefore would not have contributed to his death. In addition, his mild centrilobular emphysema also would not cause measurable pulmonary dysfunction or contribute to his death.
>
> ... In my opinion, cor pulmonale was not present. The autopsy evidence reveals a massively enlarged heart which weighed 1200 grams, approximately three times upper normal weight. Although the ventricular thickness measurements are increased above the normal limits for both right and left ventricles, the required severe pulmonary disease for the diagnosis of cor pulmonale is not present. EKG tracings are negative for evidence of right heart strain or tall peaked P waves, so-called P pulmonale. Finally, not even the autopsy prosector(s) suggest this diagnosis.

Dr. Griffin is board-certified in anatomic and clinical pathology. (EX 2).

Dr. Fino issued another report on December 7, 2001 after reviewing additional medical records on behalf of the employer. Dr. Fino concluded that:

> Although this man did have coal workers' pneumoconiosis, there is absolutely no evidence that coal workers' pneumoconiosis caused a respiratory impairment. Additionally, there is no evidence that chronic obstructive pulmonary disease caused a respiratory impairment. There

were no valid pulmonary function studies which support a diagnosis of a respiratory impairment.

What we do know is this man had very significant coronary artery disease, which caused him congestive heart failure and many problems, including hospitalizations.

This man died as a result of coronary artery disease and a sudden cardiac death. There is no evidence whatsoever to demonstrate that this man's death was either caused, contributed to, or hastened by the inhalation of coal mine dust.

(EX 4).

Dr. Hurwitz was deposed on March 14, 2002. He pointed out that in July 2000, the miner's pulse oxygen saturation on room air was 96%, indicating no hypoxia. (EX 6).

Applicable Regulations

The claimant's claim for benefits was filed on August 10, 2000 and is governed by the Part 718 Regulations. However, on January 19, 2001, substantial changes to Parts 725 and 718 of the Federal Regulations became effective. Based upon my review of the new Regulations, there are two sections that specifically deal with the question of whether these new Regulations are applicable to cases that are currently pending at the time of the enactment.

Pursuant to § 725.2(c), the revisions of this part [Part 725] shall also apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, etc. (see the C.F.R. for the complete list of exempted sections). Accordingly, with the exception of those sections listed as an exemption, the revisions to Part 725 will apply to the facts of this decision.

Pursuant to § 718.101(b), the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]..." (emphasis added). Accordingly, since the clinical evidence in the instant matter was developed prior to January 19, 2001, the newly enacted § 718, subpart B does not apply.

On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in National Mining Association v. Chao, No. 00-3086 (D.D.C. Aug. 9, 2001). Accordingly, I will apply the remainder of the newly revised version of Part 718 (i.e. subparts A, C and D) that took effect on January 19, 2001 to the facts of the instant matter.

Discussion

At the outset, I find that the District Director did not fulfill its obligation under 20 C.F.R. § 725.405(c), as it did not provide Dr. Perper with the medical evidence he stated he needed to properly evaluate this case. While Dr. Perper was provided with copies of all of the hospital records summarized above, plus those from January 10, 1995 and July 10, 2000 (which are not in the record, see DX 20), he was not provided with any of the pulmonary function studies, arterial blood gas tests, and examinations which were developed in the miner's claims at DX 30 and DX 31, despite their availability. These records show some use of inhalers, and contain varying opinions as to the miner's pulmonary status.

I also note that Dr. Perper was not provided with, and this record lacks, copies of Dr. Hashid Awan's May 14, 1990 report and the hospital report of February 23 to March 3, 1989. According to Drs. Griffin and Fino, who reviewed these reports, Dr. Awan stated that the miner was taking Proventil inhaler treatment for COPD and related the COPD to working in the mines. The hospital report includes diagnoses of silicosis and partial lobe black lung. (EX 2, 4).

My review of the medical records in evidence indicates that the miner was on two inhalers at least in 1988, a factor the employer has chosen to deny rather than address. (See Employer's closing argument at p. 3). The claimant was not asked any questions regarding her husband's use of inhalers.

As noted earlier, pages 2 and 3 are missing from Dr. Bush's report at DX 21.

This record also presents an allegation that the prosectors did not provide representative lung sections. Therefore, since this claim is being remanded anyway, this order will address that allegation.

Therefore, in order that justice be rendered under the Act by having a full disclosure of all necessary and available medical evidence, and the proper development and evaluation of this claim,

ORDER

IT IS ORDERED THAT this case is REMANDED to the District Director, Office of Workers' Compensation Programs, for further development of the record, including but not limited to the following:

1. The employer, Beth Energy Mines, Inc., is to submit the May 14, 1990 report of Dr. Awan and the February 23 to March 3, 1989 hospital report into the record;

2. The claimant, Helen M. Mucker, is to submit a statement as to her recollection of her husband's use of inhalers and any other pulmonary or respiratory medication;

3. The District Director, OWCP, is to obtain a supplemental opinion from Dr. Perper following his review of Dr. Awan's report, the February 23 to March 3, 1989 hospital report, all of the medical reports and clinical data contained in DX 30 and DX 31, and the claimant's statement ordered in paragraph 2 above, as well as all of the reviewing pathologist and physician opinions to date;

4. The employer, Beth Energy Mines, Inc., is to submit pages 2 and 3 of Dr. Bush's report, and the District Director, OWCP, is to incorporate those pages into DX 21; and

5. The District Director, OWCP, is to obtain a supplemental opinion from Dr. Mittal as to whether he provided representative lung tissue samples in this case and, if he does not remember this particular case, whether he routinely provides representative samples in his work.

SO ORDERED.

A

MICHAEL P. LESNIAK
ADMINISTRATIVE LAW JUDGE